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Citation for published version:

Ruwanpura, KN 2019, "Imaginary" Illnesses? Worker Occupational Health and Privatized Health Care: Sri Lanka's Story', *Contemporary South Asia*, vol. 27, no. 2, pp. 247-258.
<https://doi.org/https://www.tandfonline.com/doi/full/10.1080/09584935.2019.1578731>,
<https://doi.org/10.1080/09584935.2019.1578731>

Digital Object Identifier (DOI):

<https://www.tandfonline.com/doi/full/10.1080/09584935.2019.1578731>
[10.1080/09584935.2019.1578731](https://doi.org/10.1080/09584935.2019.1578731)

Link:

[Link to publication record in Edinburgh Research Explorer](#)

Document Version:

Peer reviewed version

Published In:

Contemporary South Asia

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“Imaginary” Illnesses? Worker Occupational Health and Privatized Health Care: Sri Lanka’s Story

Abstract: Sri Lankan apparel factories claim to be at the vanguard of ethical production on the global supply chain. Both to produce this image and to project their status as fair employers, industrialists offer health services at factory settings. This article focuses on two factory sites that have permanent qualified nurses to attend to illness and injuries, and medical doctors that visit twice a week. While on the face of it, these efforts are commendable, what my fieldwork signalled was that occupational health issues were inseparable from the creeping privatization of health care systems. Injuries or illnesses not treated within a “reasonable” time frame were invariably referred to the private clinics of medical doctors. Ironically, this pattern is bolstered by the proliferation of what one worker described as “imaginary” illnesses – that is, illnesses that workers concoct as a form of respite from the intense pressures of working in this sector. In this paper, I examine the ways in which workers get treated and how it is connected to an increasingly unregulated privatized landscape of healthcare. These shifts also show how the perspectives of citizenry change, despite the social welfare achievements around health and longevity of Sri Lankans.

Keywords: Sri Lanka, Apparel Industry, Unregulated private healthcare, Factory Workers, Occupational Health

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Acknowledgements: This article draws upon a three-year ESRC research grant on “Labour-Practice Responses to Ethical-Trading Codes of Conduct at Sites of Production: A Case Study of the Sri Lankan Apparel Sector” (ESRC Grant No: RES-0161-25-0181). An early version of this paper was presented

at a workshop on *Accounting for “Health” and “Safety” in the Global Garment Industry* held at the University of Sussex and benefitted from generous comments by participants there, in particular Geert De Neve, Caitlin Lynch, Alessandra Mezzadri, and Rebecca Prentice. Since then two anonymous reviewers and John Zavos, the managing editor of CSA, worked patiently to ensure its focus and analysis strengthened.

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Abstract: Sri Lankan apparel factories claim to be at the vanguard of ethical production on the global supply chain. Both to produce this image and to project their status as fair employers, industrialists offer health services at factory settings. This article focuses on two factory sites that have permanent qualified nurses to attend to illness and injuries, and medical doctors that visit twice a week. While on the face of it, these efforts are commendable, what my fieldwork signalled was that occupational health issues were inseparable from the creeping privatization of health care systems. Injuries or illnesses not treated within a “reasonable” time frame were invariably referred to the private clinics of medical doctors. Ironically, this pattern is bolstered by the proliferation of what one worker described as “imaginary” illnesses – that is, illnesses that workers concoct as a form of respite from the intense pressures of working in this sector. In this paper, I examine the ways in which workers get treated and how it is connected to an increasingly unregulated privatized landscape of healthcare. These shifts also show how the perspectives of citizenry change, despite the social welfare achievements around health and longevity of Sri Lankans.

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Introduction

Although many managers had spoken with pride of their medical facilities when I interviewed them as part of a research project focused on Sri Lankan apparel factories (Ruwanpura and Wrigley 2011), I had not expected to make visits to their in-house medical centres/clinics as part of the research. Due to my own ill health and an on-going gynecological condition, however, I became familiar with such centres in two factories both at the inception and tail-end of my extended fieldwork. The outcome of my own health experiences while at the factory sites was that I became attentive to how workers negotiated their health on a daily basis. I also became attentive to how the availability of medical facilities within factories signalled other changes to how workers negotiated

their ill bodies at work. Against a backdrop of impressive health achievement and yet iniquitous access to health care providers, this article explores the ways in which apparel sector workers increasingly seek to maintain their health by accessing the private health care sector. My argument is that, because of the way in which prevailing social structures intersect with new spaces of health care within and outside factories, workers gradually and unwittingly legitimize and provide succour to an unregulated private health care system.

Almost all factories I visited had a foundation for management claims regarding their attentiveness to workers' health and safety needs (see also Ruwanpura and Wrigley 2011). On-site clinics for sick workers with dedicated nurses and attendants were supported by qualified medical doctors visiting for consultations weekly or twice a week. Workers with on-going health conditions therefore ostensibly had ready access to medical doctors within their work setting; a creditable benefit at first glance. However, it became apparent during my fieldwork that there were emerging issues around workers' experience of these benefits, and their access to multiple healthcare facilities. My purpose is not to subject facilities offered within factories to analysis. Instead, I want to explore how the experience of occupational health and treatment within factories shapes evolving views amongst workers about the health care options accessed by them in increasingly privatised health care system. I argue that shifts in opinion as a result of the experience of workplace care has actually facilitated marketization of the much-lauded Sri Lankan public health system (Russell 2005, Jayasinghe et al 1998).

I start by reviewing the literature which demonstrates that Sri Lanka's health care achievements are many. I then briefly describe the fieldwork from which my findings for this paper emerge (see also Ruwanpura 2013, 2014a), and go on to use a number of vignettes to elucidate the ways in which workers began to access private medical clinics. While workers feel that they may be getting duped by physicians, Sri Lankan medical doctors continue to hold lofty positions because education is highly valued in a country with a stratified societal fabric. Hence workers continue to defer to medical professionals.¹ Research on other areas of South Asia emphasise key healthcare challenges:

the growth of an unregulated healthcare market; the proliferation of spurious medicines; and the variable access of citizens to crucial health needs (Harper and Jeffery 2009, Jeffery & Jeffery 2008, Shaikh & Hatcher 2005). Despite Sri Lanka's sound record on public healthcare, such issues appear to be increasingly evident in this context too (Russell and Gilson 2006). The evidence presented in this paper supports this observation. I am particularly interested in unpacking how workers give meaning and value to occupational health issues, and their connection both to processes of privatizing health care and the broader landscape of neo-liberal production frameworks within which these processes are set. The lack of a living wage results in workers doing overtime, with the outcome that they have no time for rest; fatigue and bad eating is ubiquitous. This combination not only works against good health, but also what one finds is that how workers make sense of their illness and their healthcare-seeking behaviour is revealing of their position within the neoliberal order. One worker's evocative comments about "our imaginary illnesses (api leda mawanawa)", which I discuss in more detail below, spoke strongly to these themes. She was alluding to the fact that some illnesses are at one level mentally fabricated, as a strategy to legitimize time out from the pressures of factory work. In an apparel supply chain context, where labouring women are offered through state designed policies to prospective employers as healthy workers, my research highlights the need both to puncture and to complicate a narrative of healthy and able workers. I show how a combination of neo-liberal policies and structural adjustment processes has dually impacted workplace and health care practices and experiences in a mutually constitutive way.²

Desirable Healthcare? Sri Lanka's Achievements

Sri Lanka registered a gross national income of US \$ 2,923.00 for 2012 (CBSL 2013), and lately has been characterised as a lower middle-income developing country according to World Bank typology (World Bank 2010). The country's entrance into the lower middle-income bracket is recent, yet for a "developing" nation Sri Lanka has always stood out for its remarkably impressive health indicators and care provisioning (Russell and Gilson 2006, Jayasinghe et al

1998). These achievements testify to the early Sri Lankan state's commitment to socio-economic development, and has been the subject of academic debate around the possibilities of social development and low growth (Sen 1998, Humphries 1993). Despite Sri Lanka's feats in the socio-development sphere, whether education or health, scholars have also rightly pointed to the inequities embedded in accessing health care provisioning (Jayasinghe et al 1998, Russell 2005). They note how recent neo-liberal policy shifts that have led private providers to enter the health sector, accentuating or exacerbating these inequities.

The state of worker health in the industry is already the subject of some concern, with Attanapola (2004) and Amarasinghe (2007) logging health issues around muscular-skeletal disorders and anaemia, respectively. Attanapola (2004) inquires into the health status of women workers in the largest Free Trade Zone (FTZ) and points out how workers end up normalizing illness and poor health, even though they constantly complain of muscular skeletal disorders and recurrent headaches. Consequently, she notes how workers refrain from seeking appropriate medical treatment (Attanapola 2004). Amarasinghe (2007) draws our attention to how the lack of a living wage has a bearing on overtime, where workers are economically compelled to take it on rather than walk away. She argues that its prevalence eats into rest time, and because of tiredness, workers do not pay enough attention to their nutrition intake in preparing their evening meals. Equally, they are compelled to economize because of financial constraints. Consequently, she notes how garment workers are the most affected occupation in terms of deficiency anemia and malnourishment (Amarasinghe 2007).

When scrutinized at the micro-level, then, Sri Lanka's seemingly notable achievements in terms of health indicators are a matter of debate (Russell and Gilson 2006); all the more so, as neo-liberal reforms take shape. As Jeffery and Jeffery (2008) remark, it is "vital to attend to local specificities and explore howmeta-narratives of neo-liberalism play out within inequitable social and power structures on the ground" (2008:62). How low-income classes access healthcare facilities (Russell and Gilson 2006), their ability to build trusting

relationships with different kinds of health providers (Russell 2005), and inequities embedded within it (Jayasinghe et al 1998), underpin how social structures and relations shape Sri Lanka's transition to a public-private health care system under the auspices of neo-liberal policies. In my paper, I want to build on these studies within the specific context of factory worker health to assess how regular access by medical doctors to factory premises is also used for widening their patient base for private practices in the vicinity. Accordingly, I am also interested in how the shift towards accessing private medical care shapes evolving views amongst workers on prioritizing particular types of health care facilities. Prior to presenting, discussing, and analyzing my ethnographic findings, the next section offers the reader a sense of my time in the field and the fieldwork methods employed.

In the field

My fieldwork started in December/January 2008-9 when I interviewed 25 factory managers at various levels of authority, from mid-ranking to senior managers to directors and CEOs. During this time, a couple of propitious encounters led to two factory managers opening their factories as sites within which I could do my longer-term fieldwork. This two year fieldwork stint began with a Research Assistant (RA), *Wasana*,³ becoming based at both factories from April 2009, and I joined her around July/August of 2009. She not only eased my entrance but also continued the fieldwork over a two year period when I was absent. I was placed at both these factories over a seven month period and visited each factory, on alternate days, on a daily basis. Afterwards, until end June 2011, I did return fieldtrips every four-to-six months, with each phase lasting between two-to-three months – and in this manner got an evolving sense of factory-based politics over a two-year period.

Both these factories are located in semi-rural areas of Sri Lanka, well away from any Free Trade Zone (FTZ) and outside of Colombo district. They are, by Sri Lankan standards, large production facilities with workforces of 800 and

1500 workers respectively. In both factories about 75-80% of the workforce were women, and this paper draws most heavily on women workers and their experiences.⁴ As suppliers they produce for high, middle and low-end global retailers based both in the UK and USA. Marks & Spencer, Next, Levi's, Debenhams, Calvin Klein, Eddie Bauer, Matalan, Tesco, Lily Pulitzer, for instance, were all part of their long-term client base. In terms of factory standards, factory managers claim that these factories are harbingers in adhering to global standards and ethical production practices.

My data was collected through multiple methods. Participant-observation at both factories over seven months not only offered me the opportunity to gather meticulous detail about the everyday, it also facilitated developing familiarity with workers. The long period at the factory sites meant that workers were made fully aware of our research programme and the fact that data collected on all aspects of ethical codes, including on health and safety, would be subject to use and analysis. Our long association also created a bond that offered the necessary context for interviewing 90 workers on ethical code regimes, where health and safety is one issue covered. 60 were based at these two factories and were randomly selected on their interest and willingness to be interviewed or through snowballing. The other 30 workers were selected from a host of other factories through a system of snow-balling via our initial interviewees. All workers were always interviewed outside of factory settings, most usually at their homes or boarding houses; and during the entirety of the two year period and beyond, a selected sub-group within them kept in continuous touch with us (Ruwanpura 2016). Moreover, 20 workers maintained a weekly journal over a one year period, which required both *Wasana* and I to cultivate close and continuing relations with workers. In line with research ethics protocol, all the respondents names – workers, managers, activists – and the factory sites used and visited are anonymised.

Additionally, I made day visits to other factories, within and outside of the FTZ, to get a sense of the industry. In order to triangulate my data, we carried out indepth interviews with trade unions, labour rights organizations and policy makers. We also collected media interventions on the apparel sector and

campaign material used by industrialists for analysis during this two year fieldwork period. Since I have articulated elsewhere the ways in which we were attentive to the class and gender politics and how the fieldwork landscape had to be navigated delicately (Ruwanpura 2013, 2014a, 2014b), it is not a point I focus on here. Instead, I turn to my prolonged stays at the two key factories that are the focus for this article, and via vignettes help to construct a narrative ethnography to illustrate how occupational health issues are inseparable from the increasingly privatized and unregulated landscape of healthcare. My research then addresses calls to explore how “workplaces are increasingly embedded in a variety of global processes” (Sherman 2006: 422; see also Mezzadri 2014).

Health & its Multiple Manifestations

Ong Revisited?

At one point during my initial weeks at the factory I was sitting at the canteen between lunch and tea break for workers, when I witnessed a young worker come into the canteen and fainting. I had walked into the canteen area to catch some quietness and take a moment to sit, write down and clarify my fieldnotes. There was virtually no one else in the canteen, save the nurses and medical support staff having their lunch, quite late in the day. I sat away from the two women nurses and male attendant because I wanted space to write notes down; and while from the corner of my eye I noticed two workers come into the canteen, I did not really raise my eyes. It was when I heard a thumping sound and when everyone seemed to say “vettanawa, vettanawa..alla ganna” (falling, falling; catch her/hold on) that I looked up – and I just caught her fainting. My immediate thought went first to Aihwa Ong’s work *Spirits of Resistance* (1987), where fainting spells were identified as a form of worker resistance, and whether it may have resonance in this field setting too. I then found myself in a quandry, wondering whether I should walk towards the workers and the medical staff, or simply keep observing from a distance. My semi-frozen position probably came across as rather odd; as a native, the expectation amongst the locals would have probably been that I should have immediately walked over,

showing concern and active curiosity. While Sri Lankan born and bred, twenty years of living in the West had also tempered my seemingly “natural” instincts – and sometimes I found myself being torn between curiosity and detachment; this was one such occasion. However, I was clearly disrupted from my writing; I was there to gather an ethnography of labor practices around ethical codes – and health was a much vaunted ethical realm. The commotion between the medical staff and workers was obvious enough; to not investigate would be beyond the pale. So I took a few hesitant steps towards where the medical staff had been having lunch, the worker who was lying down on the bench, and her two friends who had accompanied her and were having a word with the nurses. It was evident that the workers who had escorted the fainted worker were displeased with the nurses – because as soon as I got there, they said “See, they did not take her to the medical room soon enough; so she collapsed here. She was saying that she felt weak; when a worker says that they should take notice – isn’t it?”. Their expectation was that I would take a stance and admonish the medical staff. Since I was in no position to do so (my distinct class difference was what the workers were trying to draw upon as a form of authority), my discomfort made me inquire “what happened?” instead. I was given one version by the workers, and another by the nurses and attendant – with the medical staff insinuating that such incidents are not unusual and more generally a pretense. This response caused me even more awkwardness. It was evident that the nurses were expecting me to buy into the view around worker deception; and even as I had to work gingerly around these conflicting opinions, it was evident that the younger worker in question was pretty ill. To make her our primary concern, I said “She looks ill; we should help her get to the sick room”, which deflected attention away from me having to arbitrate a difficult situation.

This episode made me realize quite early on during my fieldwork that health issues take on multiple manifestations within the shopfloor, not all of which can be captured by auditing systems (on a similar episode, see Ruwanpura 2013, 93-95; 2014a, 229). The ways in which the health of Sri Lankan workers are affected by their exposure to toxics, and the development of physical ailments because of repetitive work and malnourishment has already been recorded

(Attanapola 2004; Hewamanne 2006, Amarasinghe 2007). In this paper I want to focus on how workers went about seeking medical treatment for their ill bodies and the ways in which they normalized accessing particular types of healthcare systems. During my time at the factories, it became apparent that workers increasingly came to rely on privatized medical assistance, even to treat a common cold or a minor ailment. Exceptionally, this involved them accessing the public health care system and sometimes hospitalization (see Van Hollen 2003). No longer were home remedies considered viable to tackle common colds or flus; instead visits to doctors to get medical prescriptions or getting hospitalized was the norm. The workers were aghast when *Wasana* or I fell ill with fever or cold that we would simply drink *kottamalli* (coriander tea), *venivalgata*, take panadol and simply bedrest, without seeking medical help. This was even more bewildering with regards to *Wasana*. Because many workers were aware that her husband was a medical doctor, they found it worrying that he was not putting her on antibiotics, considered the new normal, despite the fact that drug use can be hazardous (Harper and Jeffery 2009, Shaikh & Hatcher 2004:52). Most often these workers would protest, saying “beheth ganna” (take medicine) when they could sense we were catching a common cold or coming down with a flu. Workers shying away from self-treatment for palliative care and turning to Western medicine for common coughs, colds and flu appears all the more remarkable when considering Russell’s (2005) observation through his fieldwork, conducted only in 1998-99, that most workers’ resorted to traditional herbal remedies in the first instance (2005:1401). This shift needs explanation.

Beheth Ganna (Take medicine!)

Coming across workers who were recurrently ill with various ailments was not unusual during our time at the factories. Often times, it was that workers had a cold or a flu, while at other times they would complain of prolonged ailments. Too frequently it was also the case that workers would be at their machines or going about their sewing, packing, supervising or training tasks with visible symptoms of a cold or flu: nasal congestion, teary eyes, sore or hoarse throats, and sometimes even a running temperature. Their symptoms were often visible.

Both factories attempted to institute changes in a bid to halt recurrent colds and flus amongst the workforce. One factory tried to enforce workers to wear their face masks and around the time of a swine flu fear, they also turned-off their airconditioning; *kottamalli* (coriander tea) was also introduced during tea-breaks on a twice weekly basis. Although workers at this factory sometimes grumbled about having to take a bitter tasting herbal tea, its implementation was consistent, while getting workers to wear face masks did not last for more than two to three weeks. Even during this period, workers feigned wearing their face masks: a large section of workers simply had the mask worn just below their mouth or around their neck. If they noticed the HR or any senior manager walking around, they could quickly raise it to the position where it was supposed to be – covering the mouth and nose. It was the minority of workers who opted to wear the masks appropriately and when they did not, they said that “We know it is best for us; even if it may not always prevent illness it prevents this fine dust from going into our chest.” They were aware of the health risks they were exposing themselves to; if not in the short term then certainly in the longer period. For immediate ailments and illnesses, private medical clinics were at their door-step.

Initially I was under the impression that workers only sought the treatment of factory-clinic medical doctors. On the days that the medical doctor used to visit, I witnessed long-winding queues forming from the clinic to the canteen entrance. Because the clinic was located within the canteen area in one factory and adjacent to the canteen in the second factory, it was hard to miss workers patiently lining up. Workers were given time off production to meet the visiting doctor, on the basis of a “chit” system operated by nurses and doctors. As our familiarity with workers strengthened, I learnt that the medical doctor at the clinic was often also the practitioner they would access outside the workplace. Doctors were then taking advantage of the new spaces for setting up private practice (Jeffery and Jeffery 2008, Russell 2005), which were also emerging through their presence at factories – yet another form of private practice. Workers, for their part, sought these medical doctors for treating their own health, while at other times it was to take their family members who had fallen

ill. These episodes echo Jeffery and Jeffery's (2008) observation that patients recommend friends and family to good doctors, where trust has a bearing on the medical facilities accessed by low-income groups (see also Russell 2005). Hence medical practitioners were building their client base not just from the workers they treated within factories but also possibly the kin and friends of these workers. When we discussed the medicine prescribed to them, it became evident that workers were increasingly reliant on unregulated private clinics mushrooming in rural and semi-rural areas. Since the state does not have the resources and sometimes even the political will to make the health care market accountable (Jeffery and Jeffery 2008, Harper and Jeffery 2009), the emergent private practice in Sri Lanka was becoming unregulated in a similar fashion to its South Asian neighbours.

Beheth Ganna (take medicine) for the common cold or flu became an incontrovertible fact of their daily lives, partly because medical doctors fed into this mentality. Along with this change was the fact that workers increasingly viewed these privatized health care facilities as offering "faster" healthcare than the outpatient clinics of state hospitals (see also Russell 2005). For a variety of practical reasons associated with working life, this view held, despite worker ambivalence towards treatment received by private doctors. Worker doubts about accessing private doctors surfaced from a combination of factors, including the reality that their working lives did not permit their physical bodies to recuperate through rest, awareness that private medical doctors may be simply prescribing medication only partly apt for their condition, and on-going faith that the state facilities were better suited to respond to occupational health issues. I elaborate on these in the sections below.

Justifying Absences

Although there was a readily accessible clinic that workers were able to access within factories, this did not mean that ill workers necessarily met the medical doctor at the factory clinic. If a worker fell ill a day after the medical practitioner's usual visit day, for instance, then she or he could only seek the care of nurses. If his/her ailment was an infection that needed rest or treatment, the worker would need to seek medical attention outside the work setting.

Workers needed to offer evidence of sickness from a medical practitioner to get leave; when this was not the case, workers would continue to be at work.

Within the initial two weeks of my fieldwork, I saw *Dayani*, who had started nattering to me from my initial days, assisting a worker to walk by holding her closely and caringly – and taking her out of the shopfloor. Later on, when *Dayani* returned without her colleague, I made inquiries. She then said:

For a few days, Mayanthi had been suffering from fever – but she kept coming for work because we only have a limited number of sick leave days. Today her fever was soaring and she obviously could not work anymore; I told that the supervisor “hari na, ayeta elewanna denna” (it is not right; she needs to lie down) and it is only then we were able to take her off the line. Now she probably won’t be able to come to work for more days than if she had rested from the start.

At this point, *Avindra*, a line supervisor, came and acknowledged that a poorly worker not taking sick leave during early stages of an illness can potentially become a problem. He then went on to note how there was an instance in which an operator was so ill they had to “rush her to the local hospital.” I realised that I had to be on the watchout for sick workers and their stories because having clinics within factory premises, did not guarantee their good health.

Nimanthi had stopped me on my initial day at the factory to point out gently that my tummy was visible because of the way in which I carried my notebook – at my chest, which meant my short blouse got raised. According to her, I had suffered a wardrobe malfunction, despite the fact that a traditional attire for village women is a busty blouse and a *lungi*-like cloth (*reddai-hatte*), where the entire tummy area is visible. The irony was not lost on me. Later on, as I sat at a desk writing my notes, she came up to me to apologise; somewhat perplexed I asked about what. She said that her peers had teased her for her bravery but also pointed out that she may have embarrassed me; I said she ought not to worry about it. This memorable encounter meant that I would always be on the look out for her during my daily walkarounds, even though she never agreed to be interviewed. After a few months at the factory, *Nimanthi*

was absent for a few noticeable days; when I inquired from others on her line, they said she is probably ill. When I saw her back at work, I chatted with her – and she mentioned that she went into the local state hospital because she had a flu and stomach pain, and so spent some days in hospital. She acknowledged that a flu and stomach pain may not necessarily warrant a hospital stay but she needed the rest because she was feeling worn down. By seeking hospitalization she had the relevant medical documents to share with the factory managers. She then had a medically legitimate grounds to stay away from work for an extended period of time, which a clinic could not have provided. Depending on the state of their physical being, workers then also strategize on the most opportune type of healthcare to access and aide their time away from work. When workers found their working conditions at apparel production sites, an emblematic feature of the neoliberal economy, had worn them down, workers were willing to access facilities beyond private clinics. Although, I wondered at the time whether it is the lack of primary care facilities that make workers enter hospitals? Later I found out by visiting the local hospital with a worker that the local hospital did have an outpatient clinic, so primary facilities were available – within a 20 minute bus ride from the factory premises.

Observations at the factory then suggested that because the number of sick days were limited to 14 working days, workers were compelled either to feign strong symptoms and seek admission at the state hospital or seek care through private clinics and medical doctors. State-run outpatient clinic hours jarred with the realities of working life (see also Shaikh and Hatcher 2004, Russell 2005); 9.00 am – 5.00 pm clinic hours provided by state hospitals meant that workers were unable to access medical facilities during working hours. By seeking medical care privately, unregulated clinics conspired with the system to keep low-income workers as their long-standing patients. Equally, it shows how occupational health issues were inseparable from a privatizing health system landscape. Workers were hence given medical certificates either to get paid sick leave or unpaid leave because of common colds and flus. Equally, since often the medical practitioners running private clinics in the area were also the same doctors that made weekly visits to local factories, they were aware of the

particular stresses workers were under. Hence they were well placed to manipulate worker stresses and patient gullibility in multiple ways (see also Jeffery and Jeffery 2011, 2008, Harper and Jeffery 2009), as I outline below through a vignette signalling worker acumen in navigating their occupational health struggles as industrial workers.

Better Doctors?

Jitya is someone I had got to know through *Wasana*. They had started talking to each other over a period of many weeks. When *Jitya* found out that *Wasana's* husband was a medical doctor, she had started making inquiries about good clinicians to seek an appointment with – saying that she was not satisfied with the medical doctor she was seeking treatment from. Through these conversations, we got to know that she was having a gynaecological problem; a vaginal discharge and blood clotting. During one such occasion she mentioned to me that she was feeling better because she had started applying a cream prescribed to her; after 2-3 days of use she thought that her health was taking a turn for the better. She seemed comfortable at the point, so I did not press the matter further with her, although I thought it slightly odd that a cream alone would be sufficient for taking care of vaginal discharge and recurrent blood clotting. *Wasana* and I spoke about it, and she agreed to speak with her spouse and get his opinion. We left it at that for a while, until *Jitya* again raised inquiries with *Wasana* about appropriate gynaecologists to consult privately. When she spoke with me, I kept urging her to visit the outpatient clinic at the local state hospital saying that she would get the best doctors there too. She scoffed at this proposition saying:

The doctors there don't take us seriously – and we have to spend at least ½ a day in queue before actually seeing a doctor. Where do we have the leave, akke (sister) for that?... Anyway, they say private doctors are better – and they see us much quicker; usually after hours in the evenings or during the weekends. This is much more convenient for us.

When I tried to explain that medical practitioners seeing patients privately are also usually the same doctors working at state hospitals, this rationale seemed to fall on deaf ears. *Wasana*'s spouse was reticent about recommending other medical practitioners, but eventually yielded to her pleas to see *Jitya* at their home to go through her medical records, prescriptions, and so on. *PK*, who was undergoing training to be a consultant, then realized the General Practitioner (GP) she had been seeing was prescribing generic medication unlikely to treat a gynecological issue effectively. So he suggested that she attend a particular clinic at another nearby state hospital and he would ensure that she were seen by a suitably qualified physician; which was when she heeded his advice and got treatment that did not, at least, require her to spend money for this treatment.

The fact that *Jitya* was dissatisfied with the private doctors she had consulted, and was constantly trying to access a "better" doctor and be well informed suggests that she implicitly was dubious about private doctors. Indeed, her eventually seeking an appointment with a consultant at a state hospital suggests that workers do not necessarily confer blind legitimacy on private practitioners, which has resonance with what Jeffery and Jeffery (2011) found for India. Contrary to Russell (2005), who emphasizes the importance of trust or referrals by kin and friends, I suggest that that there are facets over and above trust that shape whether ill people access public or private care. My contention is that appropriate timing and accessibility to medical care are also formative vectors for workers who need to build strategies to access care around their employment. Since state-provided facilities have not responded to a changing work culture, workers are compelled to turn to more readily available alternative facilities. Thus, they show willingness to negotiate their workplace networks, in this case *Wasana* and her husband, to get the most appropriate care, whether public or private. Accessing state-provided healthcare, however, is usually hampered by their working hours, and the absence of contacts to help them navigate the labyrinth of referrals needed to see a consultant (see also Russell 2005, Russell and Gilson 2006).

Imaginary Illnesses

Varuni's absence from the production floor was noticed by me during one of my return fieldtrip visits after the initial 7 and ½ month stay. I had assumed that she had left the factory, but when I inquired from others on her line, they assured me that she was still at work – just simply absent. While *Varuni* was never formally interviewed, we would always engage in lengthy conversations about the production process or shopfloor politics during my walkarounds at the factory. Her absence, therefore, was felt. When she returned to work, after at least a week of nonattendance, she came by to say “hi” to me as I was seated at a desk and writing down fieldnotes:

KNR: I haven't seen you for a while. What was going on? What had happened? Were you off to get married or some such?

Varuni: (Laughingly) No, I did not get married – nothing so exciting. I was ill for a while, feeling tired and lethargic – so I took-off about 2-3 days.

KNR: 2-3 days? Are you sure? I felt more like two weeks because I just did not see you and I asked about you from others on your line too.

Varuni: I have been feel really tired, lethargic, weak and worn out for a while. It is because of these incessant long hours of work during the entire month. I simply felt exhausted after a point – and so took three days off to consult a doctor.

KNR: Do you eat well and properly – especially plenty of vegetables?

Varuni: Yes, usually I do; but working long hours means that I can't eat properly at home.

KNR: If you are doing overtime, doesn't the factory offer you dinner?

Varuni: Yes, they do – and usually the dinner is good too with vegetable curries. However, sometimes I am too tired and weak to eat. Over time this means that I become even more exhausted; it is like a spiral.

Varuni then went on to say she had privately accessed a GP and he mainly prescribed vitamins to regain her strength, and also some piriton because she was suffering from nasal congestion. When I queried whether she was sure about it, she said “I will share my prescription with you, if you want”; the next time we met, she did and it was as she had mentioned. She commented:

I think I could have obtained these over the counter from the pharmacists and did not need a prescription. Sometimes we just go to the doctor because we create an imaginary illness (api leda mawanawa) in our heads – when all we need is rest and proper nutrition.

During this conversation, in contrast to *Jitya's* experience, it was gladdening to hear that the physician had prescribed vitamins for exhaustion and tiredness.⁵ Yet, this vignette illustrated how workers, who barely make a living wage accessed medical doctors, only to be prescribed vitamins! *Varuni*, however, did not place private medical practitioners on a pedestal; she was much more attuned to the fact that the distinctions between public and private sector treatment was miniscule or non-existent – and in fact said that she probably did not need to go to the doctor to be prescribed medicines. Yet, she had to do so because getting a prescription and medical certification facilitated her ability to sign-off work, get the rest she needed and ensure that she returned to a nutritious diet. To put it differently, *Varuni* needed to offer evidence in the form of a doctor's chit simply to get the rest and nutrition that she, and other overworked and fatigued labourers like her, needed. Moreover, *Varuni's* self-understanding of her health and skepticism towards private medical care also reflected her awareness of the need to hold down her job – suggesting how her aspirations and strategies of negotiating the factory floor were not disconnected from health and well-being.

The three scenarios outlined above – relating to Nimanthi, Jitya and Varuni – exemplify the ways in which back-door privatization of the healthcare sector takes place, with potentially detrimental implications for low-income working classes (Jeffery and Jeffery 2011, 2008, Harper and Jeffery 2009, Russell 2005, Russell and Gilson 2006). Workers not only face the prospect of variable healthcare but also because they barely, if ever, make a living wage, the sums they expend on seeking private doctors are likely to put pressure on their pressing economic circumstances (see also Jeffery and Jeffery 2011, 2008, Russell 2005, Russell and Gilson 2006). Because their working day

circumscribes whether they access public or private health care systems, they are compelled to opt for the latter despite their awareness that they may not get optimal care. It also reveals how existing limited leave entitlement has a bearing on workers strategizing about which health care system they access. Decision-making by workers around accessing and “choosing” between health care system, as Van Hollen (2003) points out, is always enacted in political economic contexts. Hence, we need to be attentive to how the “macro...is always locally constructed” (*ibid* 2003:7), and how “choices are structured by such things as political economic inequalities” (*ibid* 2003:209; see also Sherman 2006). Consequently, *Nimanthi* making a decision to seek hospitalization as a way of treating herself, or *Jitya* seeking information on how to make contact with the “best” gynaecologist, or *Varuni* accessing a private health care provider, needs to be appreciated within the context of the social structures they have to navigate in their everyday lives as workers. Disregarding constraints that bear upon how workers access health care systems then ends up facilitating the increasing naturalization of accessing unregulated private health care and normalizing bio-medicalization for common ailments. In a country conventionally associated with a pluralist medical domain, including *Ayurveda*, religious healing rituals and indigenous herbal traditions (Russell 2005) in addition to Western medicine, and where free public health services offer a protective bulwark against income and asset deprivation (Russell and Gilson 2006), the gradual transfer to unregulated private health care could have unmitigated poverty consequences.

Moreover, for workers whose calculus involves weighing the pecuniary costs of accessing private vis-à-vis public health systems and getting the rest they need from their onerous working lives, where imaginary illnesses become necessary to access state-sponsored health care at times too. The financial outlays on state health for such patients is beyond the scope of this paper, but the fact that it probably imposes a fiscal burden on already constrained hospital resources is beyond doubt. My evidence suggests that outdated constraints on leave entitlement impacts on hardworking private sector workers, which in turn bears upon state coffers because public sector health care systems may be inappropriately used by exhausted workers. These intricacies barely enter

current debates around public versus private health care, nor does the material struggle of the working poor to access private medicine. The upshot correspondingly is that unregulated privatization of health care continues, with little consideration for its gains for or hindrance to the working classes.

Conclusions

My cases suggest that as Sri Lanka's low-income groups enter the labour force as manufacturing workers, they are confronted with a public health care system that has not adapted to the cadence of working classes nor to the recurring health problems discharged by new forms of employment. Limited entitlement to sick days coupled with long working days means that accessing the state sector becomes prohibitive because of the likely time they will need to spend at outpatient clinics during working days. Hence they turn to unregulated private clinics and medical practitioners who may offer them poor service or prescribe medication that can otherwise be purchased over the counter. Because a greater proportion of the laboring classes in the apparel sector belong to low-income groups (Lynch 2007, Hewamanne 2008, Mezzadri 2014), normalizing and accessing privatized health care for common ailments is likely to reverse their overall economic position and add to financial stresses (see also Russell and Gilson 2006). The limited number of sick leave days imposes tangible constraints on worker ability to access public-sector health services, but it is also a constraint that makes them rationalize accessing private clinicians. Their prudence is filtered through existing labor laws and socio-economic structures that are iniquitous and laden with power dynamics, and as such mask intricacies that require attention.

The purchase workers give to private and unregulated healthcare then needs to be appreciated via the structures that they mediate as labouring classes. It is this scrutiny which enables us, as Jeffery and Jeffery (2008:62) note, to capture the "slippages between the *intentions* and the *effects* of neo-liberal reforms." Creating manufacturing sector workers in the apparel sector was an effect of neo-liberal policies introduced in Sri Lanka over three decades ago.

Sri Lankan apparels were able to offer not just educated labor but also healthy workers, given Sri Lanka's commendable human development achievements (Sen 1988). Yet, manufacturing jobs bring with them various and recurrent health problems for workers that they are unable to get treated via the public health care system because of conflicting hours of operation and the limited nature of sick leave entitlements. Consequently, because these same neo-liberal policies advocate more active involvement for private sector medical practitioners at the primary care level (Russell 2005), workers normalize their visits to private clinicians – even for seemingly trivial illnesses. In seeking medical treatment, workers appear to be driven by how to negotiate and control everyday working life constraints via their illness. Yet, how they may in turn get tossed around by the system, whether it is their limited sick leave or to be manipulated by potentially unscrupulous and unregulated medical professionals that they access via the workplace, hardly enters scrutiny on debates on public, occupational and worker health. It is for these reasons that there is a need to be attentive to local specificities; we can then tease out how meta-narratives of neo-liberalism play out, whether within the realm of health and safety at work or from work to home.

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¹ My fieldwork focused on management-labor dynamics within the shop floor; given the focus of the larger research ambit, I did not speak with or examine the motivations of medical practitioners on the value of the care they provide through private medical services. Hence, this is a lacuna in need of further research.

² My thanks to a reviewer for suggesting that these connections are explicitly spelled out.

³ In this paper, italicized names indicate pseudonyms to protect anonymity.

⁴ See also Ruwanpura (2012) for a detailed breakdown of worker composition at these factories.

⁵ Harper and Jeffery (2009) observe that patient well-being is not necessarily compromised as feared in debates around spurious or counterfeit drugs but where "profit and well-being are in conflict", the perception that patients loose out will hold.